CONNECTICUT STATE DEPARTMENT OF EDUCATION
BUREAU OF HEALTH AND NUTRITION SERVICES AND
CHILD/FAMILY/SCHOOL PARTNERSHIPS
25 INDUSTRIAL PARK ROAD
MIDDLETOWN, CONNECTICUT 06457-1520

TO: Child and Adult Care Food Program (CACFP) Sponsors

FROM: Maureen B. Staggenborg, Director
Child Nutrition Programs

DATE: October 14, 2005

SUBJECT: Operational Memorandum #02C-06 ***ED-103 Schedule D Reimbursement Claim for Day Care Centers***

Enclosed is the ***ED-103 Schedule D Reimbursement Claim for Day Care Centers*** effective for October 1, 2005. **The information that has changed from last year includes the revision date. Please discard outdated forms on file.**

The CACFP Website is now online and may be accessed at
http://www.state.ct.us/sde/deps/nutrition/CACFP/index.html

The claim form and instructions will be available for download from the website at your convenience by the end of October. It must be noted however, that the claim form was approved by the Forms Review Committee of the State Department of Education and contains information that is required by the U. S. Department of Agriculture. Contents may not be deleted or added.

It is very important that monthly claim forms are accurately addressed to ensure timely arrival to the Bureau of Health and Nutrition Services and Child/Family/School Partnerships. Timeliness is critical to assure on-time payments to the organization. **The following address must be used for claim form submission:**

Connecticut State Department of Education
Bureau of Health and Nutrition Services and
Child/Family/School Partnerships
25 Industrial Park Road
Middletown, CT 06457-1520
Attn: Avis Kelly

IMPORTANT NOTE: *This memorandum with the attached revised claim form and memorandum #01C-06 dated October 14, 2005, which transmitted the claim submission deadlines, MUST be forwarded to the appropriate agency personnel responsible for preparing and submitting the monthly reimbursement claims to the State agency.* ***Failure to appropriately disseminate this information within your organization may result in use of the outdated claim form, late claim submission, and/or incorrectly addressed claim submission. Any or all of these factors may affect the payment of claims for your organization.***

If you have any questions contact Susan Boyle at (860) 807-2074, Celia Cordero at (860) 807-2076 or Benedict Onye at (860) 807-2080.

Enclosure

ED-103
Schedule D
Rev. 05/05
7 CFR 226.11(b)

CONNECTICUT STATE DEPARTMENT OF EDUCATION
Bureau of Health and Nutrition Services
and Child/Family/School Partnerships
25 Industrial Park Road
Middletown, Connecticut 06457-1520

Reimbursement Claim for Day Care Centers

Instructions

1. ***Complete all items, use zero or N/A where appropriate.***
2. ***Retain a copy in your file for three years or until audited.***
3. ***Return on or before the 15th of the month following the claim month to the address above.***

Name of Institution	Agreement Number	Claim Month & Year
Prepared By (Name, Title, Telephone Number)	Date Prepared	Check One ☐ Original ☐ Revision 1 ☐ Revision 2 ☐ Revision 3

Name of Site	**Number of Operating Days**	**Average Daily Attendance**	**No. of Participants Enrolled by Category**				**No. of Meals Served to Enrolled Participants**			
			Free	Reduced	Over Income	Total	Breakfasts	Lunches	Suppers	Supplements
A	B	C	D	E	F	G	H	I	J	K
1										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
GRAND TOTALS Total on last page only										

After School "At-risk" Snack Program *Only*			
No. of Sites	No. of Snacks Served	No. of Operating days	Average Daily Attendance

Sign on last page only

I CERTIFY that the information supplied above is correct to the best of my knowledge, that records are available to support this claim, that this claim is in accordance with the terms of existing Agreement(s), and that payment has not been received.

Signature of Authorized Representative *Title* *Date*

CONNECTICUT STATE DEPARTMENT OF EDUCATION
Bureau of Health and Nutrition Services and Child/Family/School Partnerships
25 Industrial Park Road
Middletown, Connecticut 06457-1520

Child and Adult Care Food Program (CACFP)

ED-103 Schedule D - Reimbursement Claim for Day Care Centers

Instructions

Enter *Enter information in appropriate boxes*

- Name of institution (sponsoring organization) and Agreement Number as shown on the approved *ED-099 Agreement for Child Nutrition Programs*
- Month and year for which claim is filed
- Name, title and telephone number of person who prepared the claim
- Date claim prepared

Check Check if claim is original submission or revision 1, 2 or 3

Enter *Enter data in boxes A–K for each individual licensed or approved site for which meals are claimed; do not list by type of child care program. If there are more than eight sites use additional page(s). Do* ***not*** *include After School "At-Risk" Program*

Note: An *Application for Individual Site* (Form ED-099 Schedule A Attachment*)* must be submitted for approval prior to entering on the claim for reimbursement. Submit the *Application for Individual Site* when there is a change to the approved site information on file at Child Nutrition, i.e., a new site added, relocated or changes to meal type. Submit written notification when site is closed or removed from CACFP.

A Name of licensed or approved site

B Number of operating days the site served meals and/or regular supplements/snacks
Do **not** include operating days for After School "At-Risk" Program

C Average daily attendance (total attendance divided by number of days the site operated during the month). Round all fractions up to the nearest whole number

D Number of participants enrolled who are eligible in the free category at the site during the month claimed

E Number of participants enrolled who are eligible in the reduced category at the site during the month claimed

F Number of participants enrolled who are eligible in the over-income category at the site during the month claimed

G Total number of all eligible participants enrolled at the site during the month claimed. Total must equal the sum of boxes D, E & F

~ over ~

Enter *(continued)*

H Total number of breakfasts served to enrolled participants at the site during the month

I Total number of lunches served to enrolled participants at the site during the month

J Total number of suppers served to enrolled participants at the site during the month

K Total number of AM, PM and evening supplements/snacks served to enrolled participants at the site during the month. Do not include After School "At-Risk" Program

TOTAL Total average daily attendance, eligibility and meals data for all sites in boxes C through K; if more than eight sites do not total until last page

Enter ***Enter data for After School "At-Risk" Program ONLY***

- Total number of *After School "At-risk"* Snack sites
- Total number of snacks served at all eligible after school sites
- Maximum number of days the program served snacks in the ***"At-Risk"*** program
- Average daily attendance (total number in attendance at all sites and divide by maximum number of days any site operated during the month). Round all fractions up to the nearest whole number

One of the two representatives authorized on the *ED-099 Agreement for Child Nutrition Programs* must sign the claim form. Complete title and date. If submitting multiple pages sign on last page only.

Submit one copy with original signature and retain a copy. The due date is on or about the fifteenth of the month following the last day of the month covered by the claim. Refer to the *Schedule for Submission of Reimbursement Claim Forms* for specific dates.